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Editorial

Medical Educators: The New Generalists Identifying the Core Traditions of the Profession to Create the Next Generation of Doctors

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This September marked 25 years since I successfully passed my MBBS finals and graduated from the University of Sydney. I am now well into the second half of a career that has allowed me the privilege and opportunity to work in the United Kingdom, the United States (US), and 4 different states in Australia across a range of hospitals, from tertiary to rural. In addition, I have taught at 6 different medical schools. Throughout my career, medicine has progressed and changed at an ever-increasing rate. This issue of *The Ochsner Journal*, with its focus on clinical education, provides a worthwhile opportunity to consider the diverse range of topics in which educators can demonstrate scholarship in the field of medical education. Medical educators face the timeless challenge of developing a new generation of doctors amid the often competing interests of healthcare in the developed world.

Over the past quarter of a century, medical researchers have advanced knowledge by developing an understanding of the cellular, molecular, and underlying genetic mechanisms of health and disease. With the advent of the randomized controlled trial, clinical practice has become better informed through evidence-based research. During this period, excellence in both research and clinical practice was achieved through the development of subspecialized clinical practices and the expansion of boundaries of knowledge via equally defined areas of research.

The practice of medicine has changed in terms of the scope and practice of individual doctors. In the US, the demarcation between hospital and specialist practice has evolved through the establishment of the hospitalist as a defined field of clinical practice.[1] Finding a general specialist in clinical practice is challenging, particularly in large urban areas where doctors frequently practice within a narrow field of their own subspecialty. Orthopedic surgeons often develop specific expertise and restrict their surgical practices to a single joint; medical subspecialists such as cardiologists often practice within a single domain of their field such as echocardiography or rhythm disturbance. Similar dramatic changes have occurred in Australia where the role of the general practitioner has changed over the past 25 years to focus on managing complex care and facilitating the delivery of multidisciplinary care in the community.[2] In 2012, general practitioners seldom practice alone, different from a generation ago.

Academic medicine has also changed. The traditional path to success first involved gaining a clinical qualification in one's chosen field. Then one would undergo further research training in a specialization that often would involve completing a research degree such as a PhD on top of obtaining specialty qualifications. An individual would achieve the rank of professor based on his or her research performance and then undertake a senior administrative role for his or her hospital service. Additionally, such individuals would then be placed in charge of their piece of the basic medical curriculum.

In 2012, senior doctors who have traveled the traditional path of specialized clinical academics are often very far removed from the requirements of the basic medical education that must prepare graduates for clinical practice regardless of their chosen field. The nature of clinical practice means that specialists working in a large tertiary hospital such as Ochsner have very highly developed areas of expertise that consequently lead to a narrow focus. As a result, medical education is now a field in its own right in which medical practitioners and interested educators work together to create the highly complex integrated teaching and assessment strategies required to deliver a modern medical curriculum.

The fields in which a medical graduate might choose to specialize are nearly limitless, and trying to predict the future medical workforce requirements has been nearly impossible for successive governments in Australia and the US.[3] If each subspecialist clinical instructor were assigned a subject and a period of weeks to teach his or her piece of the course, the standard medical curriculum could last a lifetime. For this reason, medical degrees around the world are

currently most often presented as an integrated curriculum. The integrated curriculum is a tool for managing the limits of a medical education program.

Encouraging clinicians to choose medical education as a career path is essential if we are to produce the best possible next generation of doctors. One challenge facing medical educators is to identify the core skills common across the different fields of biomedical sciences and clinical practice that students must demonstrate to graduate. Therefore, the modern medical educator must have knowledge across the breadth of clinical and scientific knowledge, and such knowledge requires generalist skills. The art of being a cutting-edge medical educator lies in identifying the core and often generalist skills required for all medical practice, even the specialized skills required for tertiary clinical research and practice. The core attributes of communication, professionalism, teamwork, and safety[4] constitute the essence of the primary goal of medical education in the US and Australia.[5] Practicing in medical education allows me to use my skills as an educator in collaboration with colleagues from all of the different clinical disciplines that contribute to the medical program.

The privilege of being allowed to impart knowledge[6] has been a distinguishing cornerstone of the profession since the time of Hippocrates. Whether you are a clinical teacher in the US or Australia, this issue of *The Ochsner Journal* highlights the cutting edge of education practice. I encourage you to read this diverse mixture of health education research articles that contribute to the evolving discipline of medical education.

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